



State of New Jersey

DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
(609) 292-7524 TDD (609) 292-7718
www.state.nj.us/treasury/pensions

RICHARD J. CODEY
Acting Governor

Mailing Address:
PO Box 295
Trenton, NJ 08625-0295
Location:
50 West State Street
Trenton, New Jersey

JOHN E. MCCORMAC, CPA
State Treasurer

FREDERICK J. BEAVER
Director

Dear Applicant:

Thank you for requesting a New Jersey State Employees Deferred Compensation Enrollment Packet.

The Deferred Compensation Plan provides you, as an eligible State employee, with an opportunity to voluntarily shelter a portion of your wages from federal income taxes while saving for retirement by supplementing your social security and pension benefits. Under the Plan, federal income tax is not due on the deferred amounts or the accumulated earnings until you receive a distribution of your account, presumably at retirement when the tax rate probably will be lower.

Enclosed you will find two forms, an enrollment request and a beneficiary request, which must be completed by you and your Authorized Personnel Representative and returned to the Deferred Compensation Office for processing. Also included are Plan Information Booklets, instructions for completing the forms and a business reply card used to obtain important feedback about the Plan from you.

If you have additional questions about enrolling in the New Jersey State Employees Deferred Compensation Plan, please contact our office at (609) 292-3605. We also have answers to frequently asked questions at our website, <http://www.state.nj.us/treasury/pensions/fact32.htm>.

Again, thank you for your interest in the Plan. We are happy to be of service to you.

Sincerely,

Edward Wade
Assistant Administrator, DC Plans

EASY AS 1 – 2 – 3

INSTRUCTIONS FOR ENROLLING IN

THE NJ STATE EMPLOYEES DEFERRED COMPENSATION PLAN

These step-by-step instructions were developed to help you complete the enclosed forms quickly and correctly. Simply follow the instructions below and return the completed forms to your Authorized Personnel Representative.

STEP #1 – ENROLLMENT REQUEST (Form #1)

- 1) **EMPLOYEE INFORMATION** – Complete statistical information such as social security number, date of birth, full name, address (including zip code), home and work telephone numbers (including area code), retirement system and membership number.
- 2) **AUTHORIZED PAYROLL DEDUCTION** – Enter the percentage (no fractional percentages) you wish to have deducted from your salary each regular pay period (for purposes of calculating a deferral percentage, base salary is reduced by pension and tax-sheltered contributions). The deferral percentage you select may be in any full percentage amount.
- 3) **INVESTMENT ELECTIONS** – Choose one, two, three or four funds in which you want your deferral to be invested. Your percentage total must be in multiples of 1% and must total 100%. Fund 1, the Bond Fund, is invested primarily in US Treasury Bonds. Fund 2, the Equity Fund, is invested primarily in Common Stock. Fund 3, the Money Market Fund, is invested primarily in CDs, NJ Cash Management Fund, Commercial Paper and US Government Securities. Fund 4, the Small Cap Equity Fund, is invested primarily in the Common Stock of companies with lower market capitalization.
- 4) **EMPLOYEE UNDERSTANDING** – Read the points listed on the reverse of the form. Any questions should be directed to the Deferred Compensation Section for clarification PRIOR to your enrollment in the Plan.
- 5) **ENROLLMENT AGREEMENT** – Your signature and date are required. You acknowledge the conditions set forth by the Internal Revenue Service code 457 and the administrative procedures set forth by the Plan. The Authorized Personnel or Payroll representative's signature and date are required from your place of employment PRIOR to receipt in the Deferred Compensation Section.
- 6) **ENROLLMENT REQUEST CONFIRMATION** – **You or your Personnel or Payroll Office should not complete this section.** Upon receipt, the Deferred Compensation Section will certify the effective date of the enrollment and return confirmation to begin payroll deductions to your Payroll Unit. You will receive by mail, at your home, confirmation of your enrollment into the Plan.

STEP #2 – BENEFICIARY REQUEST (Form #2)

- 1) **EMPLOYEE INFORMATION** – Complete your social security number and full name.
- 2) **BENEFICIARY DESIGNATION** – You must designate at least one primary beneficiary. Include the beneficiaries' name, date of birth, social security number, share (must equal 100% even if split between more than one beneficiary), home address (including zip code) and the beneficiaries' relationship to you (i.e., mother, father, son, spouse, friend, etc.).
- 3) **CONTINGENT BENEFICIARY** – You also have the option of designating one or more contingent beneficiaries (in the event all primary beneficiaries predecease you). If a contingent beneficiary is designated, include the beneficiaries' name, date of birth, social security number, share (must equal 100% even if split between more than one beneficiary), home address (including zip code) and the beneficiaries' relationship to you (i.e. mother, father, son, spouse, friend, etc.).
- 4) **NOTARY AND EMPLOYEE SIGNATURES** – All Beneficiary Request forms must be signed by the employee and notarized by a notary public. Forms submitted to the Deferred Compensation Section without the proper signatures will be rejected and returned to you through your Personnel Office.
- 5) **BENEFICIARY REQUEST CONFIRMATION** – The Deferred Compensation Section will certify the receipt of your form and return a confirmation of your beneficiary designation to you by mail to your home address.

STEP #3 – FILE WITH YOUR PERSONNEL OFFICE

Take the completed Enrollment Request and Beneficiary Request forms to your Authorized Personnel Representative. This representative will sign the Enrollment Request and then forward the Enrollment Request and Beneficiary Request forms to the Deferred Compensation Plan offices in Trenton. Your request will be processed and confirmations will be returned to you by mail. This confirmation will indicate the effective date of your enrollment and the date deferrals will begin. A schedule of Plan effective dates is enclosed for your reference.

If you have any questions concerning the Deferred Compensation Plan or the enrollment process, please speak with your personnel representative or call the Plan's offices at (609) 292-3605.

Division of Pensions and Benefits
PO Box 295
Trenton NJ 08625-0295

NEW JERSEY STATE EMPLOYEES DEFERRED COMPENSATION PLAN

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ENROLLMENT REQUEST

— FOR ADMINISTRATIVE USE ONLY —

SOCIAL SECURITY NUMBER
— — — — —

PAYROLL CENTER

CHECK DISTRIBUTION CODE

PLEASE PRINT PARTICIPANT'S NAME — <i>First, M.I., Last</i>

DATE OF BIRTH

PARTICIPANT'S ADDRESS — <i>Number and Street</i>

City	State	Zip

TELEPHONE NUMBER	Home	Work

I AM A MEMBER OF (CHECK ONE):

- ☐ PUBLIC EMPLOYEES' RETIREMENT SYSTEM
 ☐ STATE POLICE RETIREMENT SYSTEM
 ☐ POLICE AND FIREMEN'S RETIREMENT SYSTEM
☐ TEACHERS' PENSION AND ANNUITY FUND
 ☐ OTHER (PLEASE SPECIFY)

MY MEMBERSHIP NUMBER IN THE ABOVE RETIREMENT SYSTEM IS: _____

AUTHORIZED PAYROLL DEDUCTION

I AUTHORIZE THE FOLLOWING PERCENTAGE OF MY SALARY BE DEDUCTED EACH REGULAR PAY PERIOD AS MY DEFERRED COMPENSATION:

EXAMPLE: 15% ENTERED AS

0	1	5
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 %ENTER PERCENTAGE*

--	--	--

 %

*MINIMUM DEDUCTION OF 1% (SUBJECT TO DOLLAR MINIMUMS AS SPECIFIED IN PLAN INFORMATION STATEMENT) — MAXIMUM DEDUCTION OF 100%

ELECTION

I HEREBY DIRECT THAT MY DEFERRED COMPENSATION BE INVESTED AS INDICATED BELOW:

EXAMPLE: 15% ENTERED AS

0	1	5
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 %FUND 1 - (BOND):

--	--	--

 %FUND 2 - (EQUITY):

--	--	--

 %FUND 3 - (MONEY MARKET):

--	--	--

 %FUND 4 - (SMALL CAP EQUITY):

--	--	--

 %

**YOUR SELECTIONS MUST BE IN MULTIPLES OF 1%
AND MUST TOTAL 100%.**

1 0 0 %

ENROLLMENT AGREEMENT

I hereby confirm that I have received a copy of the Plan's Information Statement containing the terms and conditions of the New Jersey State Employees Deferred Compensation Plan. I have also read and understand the Memorandum of Understanding on the back of this form.

By placing my initials on this document here (____), I confirm that I have read and understand Provisions #5, 6, 7, and 8 on the back of this form, advising that I cannot withdraw any portion of my account unless I terminate employment, retire, am eligible for an emergency withdrawal, or am eligible for an in-service distribution.

I hereby request enrollment in said Plan and agree to the terms and conditions therein. **(You must read the back of this form before signing.)**

PARTICIPANT'S SIGNATURE	DAYTIME TELEPHONE NUMBER	DATE
AUTHORIZED PERSONNEL REPRESENTATIVE'S SIGNATURE	TELEPHONE NUMBER	DATE

ENROLLMENT REQUEST CONFIRMATION (DEFERRED COMPENSATION USE ONLY)

This is to confirm to the employee identified above, that the percentage of salary you indicated will be deferred effective, ____/____/____, in accordance with the Plan's provisions and that such amount will be excluded from current Federal income taxation.

ADMINISTRATOR'S SIGNATURE	DATE	BATCH NUMBER
PERSONNEL REPRESENTATIVE — FORWARD ALL COPIES, EXCEPT GOLD COPY, TO DEFERRED COMPENSATION PLAN ADMINISTRATOR		
(WHITE — ADMINISTRATOR) (CANARY — PERSONNEL/PAYROLL) (GOLD — PARTICIPANT)		

MEMORANDUM OF UNDERSTANDING

By signing the face of this form I acknowledge that I have been briefed about the New Jersey State Employees Deferred Compensation Plan (the Plan) in which I am enrolling, and have been given the opportunity to ask questions and clarify concerns. I acknowledge that:

1. I have received a copy of the Plan's Information Statement and understand the particulars therein and the investment options available to me.
2. I understand that this Plan is an IRS Code 457 deferred compensation plan and not part of any other retirement system.
3. I understand that I may defer a maximum of 100% of my compensation less any deductions under Internal Revenue Code section 414(h) or a dollar amount determined by the United States Treasury Department (for calendar year 2004 the annual dollar maximum of \$13,000; \$16,000 if age 50 or older). For the year of enrollment, only salary earned from the date of enrollment in the Plan to the year end shall be included in the calculation of maximum deferrals allowable. The annual maximum deferral may be changed upon the approval of the Plan's Board to conform with changes in the Internal Revenue Code.
4. I understand that by deferring wages, I am only deferring payment of Federal income taxes. When I actually receive my distribution, the Plan will withhold federal income tax using the method and tables required under IRS regulations.
5. I understand that participation in the Plan is voluntary and once I elect to join I cannot withdraw my contributions unless I terminate employment, retire or am eligible for an emergency withdrawal or an in-service distribution.
6. I understand that if I suffer an unforeseeable emergency as defined by IRS regulations for 457 plans, I may request the Plan Administrator to distribute a portion of my account necessary to meet the financial emergency.
7. I understand that IRS regulations define an unforeseeable emergency as a severe financial hardship to the participant resulting from a sudden and unexpected illness or accident of the participant or of a dependent of the participant, loss of the participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant.
8. I understand that I may elect to receive an in-service distribution if I have not made deferrals into the Plan for at least 24 months, and the total value of my account does not exceed \$5,000. I also understand that I may not make deferrals under the Plan for one year after receiving an in-service distribution and that only one such distribution is allowed to me while enrolled in the Plan.
9. I understand that there will be a fee charged to cover the administrative costs for Plan operation. The charge, as of July 1, 2000, is a net asset fee of 8 basis points (0.08%) per year. This fee will be charged against total Plan assets each month at the rate of one-twelfth of the annual rate. The rate charged may be increased or decreased upon the approval of the Plan's Board to assure that sufficient funds are available to cover administrative operating costs.
10. I understand that I may submit a change form to increase or decrease my payroll deductions on a monthly basis.
11. I understand that I may submit a change form to change my investment election on a monthly basis.
12. I understand the transfer of fund balances may be made in multiples of 1% of my entire account balance and will be effective on the last day of the calendar month in which the request is received by the Plan's administrator.
13. I understand updates of name changes, address, beneficiary, and beneficiary address are the participant's responsibility.
14. I understand that the Plan's assets are held in trust for the benefit of myself or my beneficiaries. However, neither I nor my beneficiaries will have any property interest in any specific trust asset because of my election to defer compensation under this Plan.
15. I understand that I am responsible to advise the Division of Pensions and Benefits Defined Contribution Plans Unit of my separation from service. This notification must occur at least 20 days prior to the commencement of benefit payments.
16. I understand the earliest payment(s) may commence from the Plan is 27 days after the close of the month in which the event occurs providing the Distribution Request Form is filed timely.
17. I understand that funds deferred under IRS Code 457 plans are not eligible for special five- or ten-year averaging.
18. I understand that if I have any questions about the Plan, I may speak with a counselor at the Plan's offices located at New Jersey Division of Pensions and Benefits, 50 West State St., PO Box 295, Trenton, New Jersey 08625-0295. I may also call the Plan's office at (609)292-3605.

NEW JERSEY STATE EMPLOYEES
DEFERRED COMPENSATION PLAN

PO Box 295
Trenton, NJ 08625-0295

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BENEFICIARY REQUEST

— F O R P E R S O N N E L U S E O N L Y —

SOCIAL SECURITY NUMBER	SUFFIX
— —	

PAYROLL CENTER

CHECK DISTRIBUTION CODE

PLEASE PRINT Participant's Name — *First, M.I., Last*

BENEFICIARY DESIGNATION

I hereby designate as my beneficiary(ies) the following named person(s) to receive upon my death the unpaid balance of proceeds due me as the result of my participation in the Plan. Payment will commence as soon as possible after the event. I reserve the right to change this designation at any time prior to my death, in accordance with the Plan's provisions. All beneficiaries are required to have Social Security numbers. Additional beneficiaries may be listed on a separate sheet; be sure the sheet includes all requested information, is signed, dated and notarized.

Primary Beneficiary — If any Primary Beneficiary should predecease me, pay that share to all other Primary Beneficiaries.

NAME	ADDRESS	DATE OF BIRTH	S.S.N.	SHARE	RELATIONSHIP
1. _____	_____	_____	_____	_____ %	_____

2. _____	_____	_____	_____	_____ %	_____

Contingent Beneficiary — If all Primary Beneficiaries should predecease me, pay all shares as follows:

NAME	ADDRESS	DATE OF BIRTH	S.S.N.	SHARE	RELATIONSHIP
1. _____	_____	_____	_____	_____ %	_____

2. _____	_____	_____	_____	_____ %	_____

METHOD OF DISTRIBUTION

If at the time of your death you have not begun distribution from the Plan and you are under normal retirement age, your beneficiary may elect to defer the distribution of the amounts deferred until the year in which you would have attained normal retirement age. The beneficiary must make this election no later than two months following the date of death and, once made it may not be revoked. Upon making such an election, the beneficiary need not select the method of payment, or if selected, may change the method elected no later than one month prior to the date payments are to commence. The beneficiary will receive a lump sum distribution if method of payment is not selected at least one month prior to the date payments are to commence.

If you have separated from employment and are receiving benefits from the Plan, your named beneficiary will receive payment(s), at the event of your death, with the same frequency and for the duration of the period previously selected by you if you have named your surviving spouse as your beneficiary. An exception is the case of payment made to a non-spouse, in which case payments will continue for the same duration as selected by you, but not to exceed five years from your date of death.

In the event of your death, your beneficiary should contact the Plan Administrator for benefit information. If your beneficiary should predecease you, file a new *Beneficiary Request* form with the Administrator. A new *Beneficiary Request* form will supersede all others on file. Please call the Administrator at (609) 292-3605 for any assistance.

REQUIRED SIGNATURE

SIGNATURE OF PARTICIPANT	DATE	
STREET ADDRESS OF PARTICIPANT		
CITY	STATE	ZIP CODE

BENEFICIARY REQUEST CONFIRMATION (Deferred Compensation Use Only)

This is to confirm receipt of this form by the Deferred Compensation Section.

DEFERRED COMPENSATION REPRESENTATIVE'S SIGNATURE	DATE
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